STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445406	A. BUILDING _____ B. WING _____	05/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	901 COUNTY FARM RD MURFREESBORO, TN 37127

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F 000	INITIAL COMMENTS During the annual Recertification survey conducted on May 10 -12, 2010, at Community Care of Rutherford, complaints #24972, #25031, #25618, #24721, and #24745 were investigated and no deficiencies were cited under 42 PART 483.13, Requirements for Long Term Care.	F 000	Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeals proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. The Facility does not waive any QA or self critical examination privilege, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review, and staff interview, the facility failed to ensure, on two occasions, to provide the required assistance and use the appropriate equipment for one resident (#21) of twenty-five records reviewed. The failure of the staff not providing the necessary assistance and using the appropriate equipment resulted in a fractured right hip to resident #21. The findings included: Medical record review revealed resident #21 was admitted to the facility on March 22, 2004, with diagnoses including Diabetes Mellitus, Hypertension, Vascular Dementia, Depressive Disorder, Joint Contracture, Congestive Heart Failure, and Cerebrovascular Accident with Right	F 323	***Facility will ensure environment remains as free of accidents hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.*** ***Facility will provide the required assistance and use the appropriate equipment for each resident.*** **1. Corrective action(s) accomplished for resident # 21** 5/14/10 MD notified of survey and reassessment findings. 5/14/10 Plan of care reviewed and current: 1) Bed at lowest position, 2) Trapeze bar for self positioning in bed, 3) Upper ½ siderails x 2, 4) Bilateral bed bolsters for top ½ bed, 5) Pro Lift 1 with 2 person transfer, 6) Air mattress to bed, 7) Splint to right ankle and right hand, 8) Pull alarm in bed and chair. 5/21/10 Pull alarm in bed and chair discontinued. 5/22/10 Resident #21 assessed/screened by Physical Therapist and Director of Nursing for appropriate fall intervention, and transfer and positioning device. 5/25/10 Staff providing bed side care inserviced by LN (licensed nurse managers) related to resident current plan of care	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlene M. King — TITLE: Administrator — (X6) DATE: 5/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 Sided Hemiparesis. Medical record review of the resident's care plan initiated September, 2009, revealed the resident was at high risk for falls. Continued review revealed the care plan was updated December 17, 2009, with the intervention "...assist (resident) 1-2 (one to two persons) using gait belt..." Continued review of the care plan revealed the intervention was updated March 17, 2010, to "...2 people with gait belt..." Medical record review of the Minimum Data Set dated March 9, 2010, revealed the resident was totally dependent with two plus person physical assistance for transfers; extensive assistance with two plus persons physical assistance for bed mobility; and extensive assistance with one person physical assistance for toilet use, personal hygiene and bathing. Medical record review of the nursing note dated February 6, 2010, revealed "...was called in resident's room...was informed resident slid down w/c (wheelchair) while transferring from toilet to w/c...Tech helped...slide to floor and went for help." Two staff members "helped...to get to...electric w/c with gait belt...informed resident had skin tear on right lower leg...denies pain." Review of a facility investigation revealed on February 6, 2010, at 3:25 p.m., the resident had fallen. Further review revealed "1-2 person assist needed to transfer and/or ambulate...resident slid off w/c (wheelchair) while transferring from the toilet to w/c (electric)...Found a skin tear on right lower leg near ankle...Resident helped up by 2 staff and gait belt." Further review revealed "careplan transfers with 1-2 assist and gait	F 323	**2. How will other residents having the same potential to be affected be indentified and corrective action accomplished?** 5/15/10 List of residents with falls since 1/1/10 were reviewed and Care Plans for all residents with high risk for falls /assistive or positioning devices were reviewed by the ICP (Interdisciplinary Care Plan) Team to ensure updated care plan related to MD order for positioning devices. 5/17/10 Positioning Device Audit (observation of residents) began every shift for 72 hours by LN managers to observe placement of assistive devices and resident specific needs. 5/17/10 – Orientation training reviewed and revised by Compliance Consultant to include training as outlined below for all new clinical staff. 5/20/10 Care Plans for all residents without assistive / position devices were reviewed and updated by the MDS RN/ MDS LPN to ensure accuracy. 5/20/10 Physical or Occupational Therapy completed screen on those residents observed with positioning or assistive devices to ensure most appropriate and least restrictive device was ordered for each resident to decrease risk for falls 5/21/10 All clinical staff inservices with return demonstration completed (except one LN and one prn CNA not currently on schedule who will be inservice upon return to work – one out of country and the CNA 's son was admitted to hospital). Inservices included: 1. Bed/body alarm Policy conducted by Restorative LPN; 2. Gait Belt use Policy conducted by Restorative CNA;	

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F 323	Continued From page 2 belt...not follow plan of care and using gait belt". Review of the hand written statement of the Certified Nurse Aide (Technician) involved in the February 6, 2010, incident, revealed the resident "was in the bathroom with light on for help. I went in and helped...sit on the toilet. When finished, I helped...get up. When...was going to sit on...chair...sat at the edge started sliding on the floor. I could not pull...back up on the chair by myself so I told...to let go of the bar...was holding because it was a struggle. So...sled (sic) down in a sitting position in front of...chair. I called for help..." Medical record review of the nursing note dated April 1, 2010, at 7:10 p.m., revealed "CNT (Certified Nurse Technician) trying to assist res (resident) to commode when...legs gave out. CNT stated that 'res right leg was curled under...body'...4 (four) CNT worked together to help res off floor to bed using lift...c/o (complaining of) unbearable pain to right hip and right leg...sent to ER (Emergency Room)." Review of a facility investigation revealed the resident fell on April 1, 2010, at 7:10 p.m., complaining of pain in right hip and right leg. Further review revealed "1 - 2 person assistance needed to transfer and/or ambulate...equipment used appropriately?...No, no gait belt." Further review reveled the "CNT trying to assist res (resident) to commode when...legs gave out. CNT stated that 'right leg was curled under...body.'...4 (four) CNT worked together to help res off floor to bed using lift. C/o (complaining of) unbearable pain to right hip and right leg...sent to ER." Further review revealed "CNT did not transfer per plan of care. Walked	F 323	3. Resident Transfer and Handling policy conducted by Restorative LN and CNA; 4. CNA Care Plan Communication Policy conducted by Admissions RN (new policy); When a change is made to the resident plan of care a notation will be placed in the front of the CNA care plan book on brightly colored paper to alert the CNA to a change. The CNA will initial review of the Communication Form to indicate their awareness of the change in plan of care; 5. Care Plan Meeting Attendance Policy – (revised) conducted by Admissions RN; Charge Nurse or CNA caregiver responsible for resident will be in attendance at the regular Interdisciplinary Care Plan meeting. Schedule will be posted at the nursing stations as staff reminder; 6. Fall Interventions Other Than Assistive Device/Restraint conducted by Staff Development LPN. List of possible interventions placed in front of MAR and CNA documentation book; 7. Assistive Device Monitoring Tool for the bedside audit conducted by LPN Case Manager; 8. CNA skills competency completed at time of hire and reviewed annually was updated to include knowledge of devices, restraints, fall interventions, types of transfers and lifts (documentation same as Orientation training, Item 2 C above). 5/19/10 UIRS guidelines reviewed by DON with Compliance Consultant related to appropriate reporting process. 5/21/10 Observation of placement of assistive devices and positioning audits continue by Licensed Nurses to ensure compliance with plan of care and Therapists to ensure most appropriate device is in place (documentation same as Observation of	

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F 323	Continued From page 3 off job after incident. Resident should have been transferred with 2 (two) people." Medical record review of the nursing note dated April 2, 2010, at 12 a.m., revealed "ER phoned to find out...status. Received report that...has been admitted...for right hip fracture." Interview with the Director of Nursing, on May 12, 2010, at 1:16 p.m., in the conference room, revealed the CNT involved in the February 6, 2010, incident, and the CNT involved on April 1, 2010, incident, were interviewed and both were aware the resident required two person assist with a gait belt for transfers. Further interview revealed the CNT involved in the April 1, 2010, incident, had been suspended for one day on March 26, 2010, for "not following plan of care for transfer. Care issues discussed..." The facility's failure to ensure the staff was providing two person assistance with a gait belt for transfers resulted in a fractured right hip for resident #21. C/O # 25511	F 323	placement, Item 2 B above). Facility Therapy and nursing staff will continue to screen / assess all residents on admission, return from hospital stay, following an incident and at least in accordance with the RAI (Resident Assessment Instrument) schedule to ensure appropriate assistive or positioning device. Therapy evaluations will be conducted when indicated and MD will be informed of resident needs. 3. **Measure put in place or systemic changes made to ensure deficient practice does not recur.** 5/17/10 Licensed Nurse Managers assigned as unit managers to oversee resident care issues. They will be responsible through a daily audit for review of changes to MD orders, resident status, care plan updates and staff communication to ensure continued communication of changes in resident needs and Care plan changes. Incidents, changes to the resident MD orders and needs for positioning / assistive devices will be reviewed daily by the LN (Licensed Nurse) managers and reported during the morning Clinical meeting to ensure care plan and CNA (Certified Nursing Assistant) care plan updates are recorded in timely manner. MDS office will be responsible for reviewing all fall risk assessments, new MD orders and incident reports to assess the resident need for revised plan of care to ensure appropriate plan of care. MDS office will be included in the Fall Committee and responsible for tracking and trending incidents to ensure compliance with care plan updates and MD orders. CNA or Charge Nurse responsible for resident daily care will be in attendance at	

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F 323		F 323		

the resident care plan meetings (documentation same as Clinical Staff Inservices, specifically Item 2 C, 5 above).
Unit Licensed Nurses or Charge Nurses will be responsible for conducting at least one audit per shift to ensure appropriate assistive / positioning devices are in place.

4. **How will the corrective action(s) be monitored to ensure the practice will not recur?**

Unit License Managers will review new admission orders and all telephone orders daily Monday through Friday to ensure plans of care are updated and communication tools are in place for licensed and bedside care staff. Director of Nursing or Assistant Director of Nursing will ensure audits are conducted for on-going compliance. All findings will be tracked and trended though the Quality Assurance Program and forwarded to the QAC (Quality Assurance Committee) for review, recommendations and identification of staff training needs.
Compliance Consultant will review QA findings and conduct random chart and observation audits during scheduled visits
Facility Administrator will ensure all findings and recommendations are evaluated during the facility's QAC meetings which will be conducted at least monthly. Attendees will include but not limited to the Medical Director, NHA, DON, MDS Licensed Nurse, Social Workers, Activity Directors, Certified Dietary Manager, Maintenance and Housekeeping Directors.

5/26/10